Michigan Department Of Community Health

MEDICAID VENTILATOR DEPENDENT CARE AUTHORIZATION

Complete this request with diagnosis information.

FAX TO: MDCH Long-Term Care Services at **(517) 241-8995**

Hospital Name

Beneficiary Name	**Facility Name**		
Beneficiary ID Number	**Facility Street Address**		
Admission Date	**Facility City**	**State**	**Zip**
Anticipated Date of Discharge to Long-Term Care	**Provider Contact Name**		
Provider ID Number	**Provider Contact Phone Number** **( ) -**		
Diagnosis			
Physician's Signature	**Date**		

MDCH USE ONLY:

Prior Authorization Number

APPROVED	**DENIED**
☐ As Presented ☐ As Amended	☐

Start Date	**End Date**	**Number of Days**	**Total Daily Vent Rate**
			$

MDCH Signature Date

Authority: Title XIX of Social Security Act

The Department of Community Health is an equal opportunity employer, services, and. programs provider

MSA-1635 (06-05) Previous editions are obsolete.